



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STUART J NATHAN PHD
2450 FONDREN STE 312
HOUSTON TX 77063

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Received Date

October 24, 2003

MFDR Tracking Number

M4-04-2869-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Request for reconsideration went out for the difference up to \$100 an hour. We have been paid at \$74.00 an hour, \$3034.00. The \$100.00 an hour for 40.75 hours of services would be \$4,075.00, making a difference of \$1,041.00."

Amount in Dispute: \$4,272.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent submitted a response to the request for medical fee dispute resolution; however, a position summary was not included in their response.

Response Submitted by: Texas Mutual Insurance Co., ., PO Box 12029, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2003, May 14, 2003, May 15, 2003, May 16, 2003 May 20, 2003, May 21, 2003, May 22, 2003, May 23, 2003	CPT Code 97799-CP	\$4,272.25	\$ 1,041.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets out the procedures for fair and reasonable reimbursement.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 14, 2003, August 28, 2003, September 22, 2003

- M – No MAR
- YM – The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011 (D).
- O – Denial after reconsideration.
- YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed.
- D – Duplicate bill.
- YD – Duplicate appeal. An appeal of the original audit decision was previously performed for these services.

Issues

1. Did the requestor support their request for additional fair and reasonable reimbursement?
2. Is the requestor entitled to reimbursement?

Findings

1. In support of the requested reimbursement, the requestor submitted two previous Medical Dispute Resolution Findings and Decisions and redacted explanations of benefits from an insurance carrier. The requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.

1996 Medical Fee Guideline, Medicine Group Rule (II)(C) indicates if the Requestor is a CARF accredited program modifier AP would be applied. If the Requestor were not a CARF accredited program then 20% reduction would be applied. The Requestor did not use the modifier AP so billing is subject to this 20% reduction.

Per 28 Texas Administrative Code §134.202(e)(5)(E)(ii) reimbursement shall be \$125.00, *adopted to be effective May 16, 2020, 27 Tex Reg 4048.*

2. Review of the submitted documentation finds that reimbursement is due. Therefore, the billed amount of \$125.00 per hour will be reduced 20% that equals \$100.00 per hour x 40.75 billed hours = \$4,075.00 - \$3,034.00 (Carrier reimbursement) = \$1,041.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,041.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,041.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 2, 2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.